Bureau of Health Care Quality & Compliance (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING NVS3768HIC 05/07/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **6424 CAYLEY COURT** FLORENCIO'S HOME SWEET HOME LAS VEGAS, NV 89110 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) H 000 Initial Comments H<sub>000</sub> POC occepu This Statement of Deficiencies was generated as a result of a State Licensure survey conducted in your facility on 05/07/09. This State Licensure survey was conducted by authority of NAC 449, Homes for Individual Residential Care, adopted by the State Board of Health on November 29, 1999. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The census at the time of the survey was 1. One resident file and two employees file were reviewed. The following deficiencies were identified: H 019 H 019 Director Duties-No FA/CPR NAC 449.15523 Director: Duties. (NRS 449.249) The director of a home shall: 4. Ensure that a caregiver, who is capable of meeting the needs of the residents and has been trained in first aid, and cardiopulmonary resuscitation, is on the premises of the home at all times when a resident is present. i) HO19 - Employée #2 submit a current first aid and CPR This Regulation is not met as evidenced by: Based on record review and staff interview on

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

05/07/09, the facility failed to ensure that 1 of 2

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 05/07/2009						
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H 019	Continued From page 1			H 019	dand to BLC; Pls	re doc						
	caregivers had received training in cardiopulmonary resuscitation (CPR) and first aid (Employee #2).  Findings include:  The file of Employee #2, hire date 09/05/05, contained a CPR and First Aid card with an expiration date of December 2008.			2)	, "A"							
					All employee will be in re-certification prior to expiration Administrator will for compliance	datis.						
H 050	Tuberculosis-Employees			H 050								
	NAC 441A.375 Medical facilities, facilities for the dependent and homes for individual residential care: Management of cases and suspected cases; surveillance and testing of employees; counseling and preventive treatment.  1. A case having tuberculosis or suspected case considered to have tuberculosis in a medical facility or a facility for the dependent must be managed in accordance with the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200.  2. A medical facility, a facility for the dependent or a home for individual residential care shall maintain surveillance of employees of the facility or home for tuberculosis and tuberculosis infection. The surveillance of employees must be conducted in accordance with the recommendations of the Centers for Disease Control and Prevention for preventing the transmission of tuberculosis in facilities providing health care set forth in the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200.  3. Before initial employment, a person employed in a medical facility, a facility for the dependent											

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STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING B. WING NVS3768HIC 05/07/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **6424 CAYLEY COURT** FLORENCIO'S HOME SWEET HOME LAS VEGAS, NV 89110 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) H<sub>050</sub> H<sub>050</sub> Continued From page 2 or a home for individual residential care shall have a: (a) Physical examination or certification from a licensed physician that the person is in a state of good health, is free from active tuberculosis and any other communicable disease in a contagious stage: and (b) Tuberculosis screening test within the preceding 12 months, including persons with a history of bacillus Calmette-Guerin (BCG) vaccination. If the employee has only completed the first step of a 2-step Mantoux tuberculin skin test within the preceding 12 months, then the second step of the 2-step Mantoux tuberculin skin test or other single-step tuberculosis screening test must be administered. A single annual tuberculosis screening test must be administered thereafter, unless the medical director of the facility or his designee or another licensed physician determines that the risk of exposure is appropriate for a lesser frequency of testing and documents that determination. The risk of exposure and corresponding frequency of examination must be determined by following the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 4. An employee with a documented history of a positive tuberculosis screening test is exempt from screening with skin tests or chest radiographs unless he develops symptoms suggestive of tuberculosis. 5. A person who demonstrates a positive tuberculosis screening test administered pursuant to subsection 3 shall submit to a chest radiograph and medical evaluation for active tuberculosis. 6. Counseling and preventive treatment must be

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Bureau of Health Care Quality & Compliance (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER** A. BUILDING B. WING\_ NVS3768HIC 05/07/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER

FLORENCIO'S HOME SWEET HOME		6424 CAYLEY COURT LAS VEGAS, NV 89110				
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H 060	Continued From page 4		H 060	regarding Tuberulous	Testy	
H 060	Ultimate User Agreement		H 060	)	0	
	NRS 453.375 Authority to possess and administer controlled substances. A co substance may be possessed and admi by the following persons:	ntrolled				
	6. An ultimate user or any person whor ultimate user designates pursuant to a vagreement.					
	NRS 454.213 Authority to possess and administer dangerous drug. [Effective to December 31, 2007.] A drug or medicine referred to in NRS 454.181 to 454.371, may be possessed and administered by	hrough ne inclusive,				
	10. An ultimate user or any person des by the ultimate user pursuant to a writte agreement.		: :			
	This Regulation is not met as evidence Based on record review on 05/07/09, the failed to obtain an Ultimate User agreed authorizing the facility to administer met to 1 of 1 residents (Resident #1).  Findings include:	e facility ment	)	HOLD. File of Resident submit a signed ellips user agreement between patient power of Attor		
	The file of Resident #1 failed to have a Ultimate User agreement in it.	signed	a)	and administration facility Pls. see doc  I C "  It is administration responsibility to ensu	umint.	

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G2N711 files agreement outpontinuation sheet 5 of 5 Signed between reportable